State of Missouri
SHRMC
State Human Resource Management Council

MINUTES
Wednesday, October 12, 2005
8:30 a.m. – 10:30 a.m.
Missouri Department of Transportation, 1320 Creek Trail Drive

The October 12, 2005 meeting was called to order at 8:30 a.m. by Co-Chairs Micki Knudsen and Les Balty.

Agenda Items

SAM II Update – Jan Heckemeyer, Office of Administration
Jan shared the statistical feedback from the vendor demos. Agencies are encouraged to submit any additional feedback or comments to OA regarding the demonstrations.

NOTE: On October 13, Micki forwarded an e-mail from Jan regarding the summaries of the feedback from the ERP vendor demos.

OA Update – Gary Fogelbach, Office of Administration
Gary gave an update regarding various rule changes under review by the PAB. These rule changes are primarily "cosmetic" in nature and either provide clarification or are being changed in accordance with recent statutory changes. Gary also advised the group that by Executive Order, the Governor has expanded the number of employees, who can receive paid leave for voluntary disaster service through SEMA recognized agencies, from 25 to 50. If an agency is interested in knowing the number of employees that have been approved for leave, contact Norma Wieberg at 522-1258.

Gary reminded the group that the Pay Plan Recommendations were approved by the Personnel Advisory Board and submitted to the Governor on August 24, 2005.

NOTE: You can view the recommendation on the Division of Personnel's web page at: http://www.oa.mo.gov/pers/recommendations07.pdf.

Gary gave an update on the Ease System. There was a hold on new classes, but they are starting to open classes again. There have been 20,000 applications for 54,000 jobs since May 1. If any agency has questions regarding an applicant's educational credentials, OA can assist in verifying college/university accreditation. Agencies also have the option of requesting a transcript from the applicant.

Suicide Prevention Awareness – Aurita Prince Caldwell and Debbie Meller, DMH*
Aurita gave an overview of the risk factors, statistics, and prevention tips regarding suicide. The Department of Mental Health offers free suicide prevention training workshops.

Next SHRMC Meeting: November 9, 2005, 8:30 a.m.
Location: MoDOT, 1320 Creek Trail Drive, Conference Room I-70

Meeting adjourned.

***THE HANDOUTS AND PRESENTATION FOR THIS TOPIC ARE BELOW.**

Aurita Prince Caldwell, M.Ed.

Policy Liaison
Department of Health and Senior Services
Section of Healthy Families and Youth

Definition

- Suicide or Completed Suicide (terms or used interchangeably)
  - Someone takes his or her own life with conscious intent by lethal means
  - Use of the word "successful" to describe suicide is discouraged.

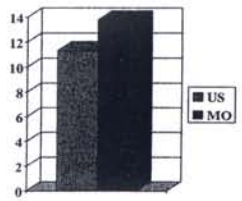
Is Suicide a Problem?

US 31,000 deaths by suicide

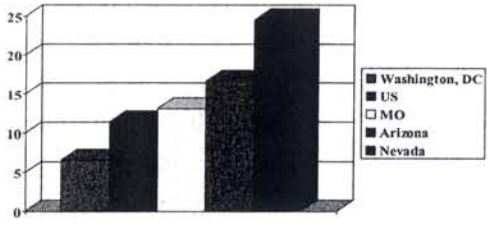
MO 710 deaths by suicide

Is Suicide a Problem In Missouri?

- 710 deaths by Suicide per year
- Missouri ranks 23 in the nation.
- Missouri's suicide rate is higher than the national rate.



Western States have higher Suicide Rates

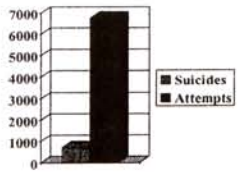


Definition: Suicide Attempt

- A non-fatal outcome for which there is evidence (either explicit or implicit) that the person believed at some level that the act would cause death.
- A suicide attempt may or may not cause injuries.
- Includes acts that are thwarted due to discovery and resuscitation.

Are attempted Suicides a problem?

- Outpatient visits and admissions
- nearly 10x the # of suicides in Missouri
- Above the national average of 8x
- outpatient visits increased by 20%



Definition: Survivor

- Any individual who was emotionally close to a person who died by Suicide.
- Grieving process is complicated by:
  a. The untimely, unexpected and unnatural death, and
  b. The stigma associated with suicide.
- Survivors are at an increased risk of Suicide (especially during the 1st six months)

Survivors

- Each suicide intimately affects 6 other people (estimate)
- 1 in 59 people are survivors (based on # of suicides in the last 25 years in the US
- # grows by 180,000 each year

Advancing the Scientific Understanding of Suicide

- US Public Health Service - 1958
- National Institute of Mental Health - 1966
- American Association of Suicidology
- American Foundation for Suicide Prevention
- Center for Disease Control and Prevention - 1983

Suicide is a public health problem: Using a Public Health Approach

Defining the Problem
Identify Risk and Protective factors
Develop and Test Interventions
Implement Interventions
Evaluate Effectiveness

Risk Factors

A combination of stressful events, situations, and/or conditions that may increase the likelihood of suicide, especially when several coincide at any given time.

Demographic Risk Factors

- Age
- Gender
- Race
- Geographic Location
- Marital Status

Biopsychosocial Risk Factors

- Mental Disorders
- Alcohol and other substance use Disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempts
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Sociocultural Risk Factors

- Lack of social support and sense of isolation.
- Stigma associated with help-seeking behavior
- Barriers to accessing health and mental health services (substance abuse treatment)
- Certain cultural and religious beliefs (belief that suicide is a noble resolution)
- Exposure to, including through the media, and influence of others who have died by suicide.

Protective Factors

Factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment.

Protective Factors

- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted Access to highly lethal means of Suicide.
- Strong connections to family and community support

Protective Factors

- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

Evidence-based Strategies

Case Identification	Risk Factor Reduction
1. School-based Awareness	1. Restrictions of Lethal Means
2. Hot Lines	2. Media Education
3. Gatekeeper Training	3. Postvention/Crisis Intervention
4. Screening	4. Skills Training

Case Identification Strategies

School-based Suicide Awareness Curricula

- Based on the theory that students are more likely to turn to peers than adults
- Studies report no benefits, some benefits, and detrimental benefits
- No help-seeking benefits shown - more maladaptive coping responses among boys
- increase suicide ideation among adolescents

Case Identification Strategies

Crisis Centers and Hot lines

- Theory that individuals will utilize these services in crisis situations
- Effective only if people use them.
- Most effectively used by young white females - significant reduction in rates
- Little or no male use.

Case Identification Strategies

Gatekeeper Training

- Develop knowledge and skills of natural helpers to identify individuals at risk
- Studies showed an increase knowledge an skills among those trained.
- Significant improvement of trainees in their preparation for crisis.

Case Identification Strategies

Screening

- Purpose is to identify at risk individuals through direct screening.
- Individuals who screened "at risk" showed higher levels of risk factors and lower levels of protective factors
- Large number of false positives necessitates a second-stage evaluation.

Risk Factor Reduction Strategies

Restriction of Lethal Means

- Reduce access to lethal methods during periods of impulsiveness - targets the most common method
- Studies suggest Firearm restrictions can reduce overall suicide rate.
- Safer prescription practices, reduction of carbon monoxide content of automobile exhaust

Risk Factor Reduction Strategies

Media Education

- Produce media stories that minimize harm through suicide contagion.
- Emphasizes media's positive role in educating the public
- Decline in rates following implementation of guidelines for news reporting in Australia

Risk Factor Reduction Strategies

Postvention/Crisis Intervention

- Assist survivors in the grief process and identify and refer "at risk" survivors.
- Goal is to conduct timely interventions towards survivors to reduce subsequent morbidity and mortality
- Little research, only public concern over clusters

Risk Factor Reduction Strategies

Skills Training

- Emphasis on the development of problem solving, coping and cognitive skills.
- Produce an immunization effect against suicidal feelings and behaviors
- Several studies show evidence of effectiveness

Limited Access to Resources

- Mental Health
- Substance Abuse
- Barriers:
  - Financial
  - Structural
  - Personal
  - Associated Stigma

Challenges to Overcome

- Incomplete knowledge base
- Development of interventions
- Allocating scarce human and monetary resources
- Prevention and/or treatment argument
- Tendency towards short term planning

QPR

Ask A Question, Save A Life

QPR

Question, Persuade, Refer

QPR

- QPR is <u>not</u> intended to be a form of counseling or treatment.
- QPR <u>is</u> intended to offer hope through positive action.

QPR

Suicide Myths and Facts

- **Myth** No one can stop a suicide, it is inevitable.
- **Fact** If people in a crisis get the help they need, they will probably never be suicidal again.
- **Myth** Confronting a person about suicide will only make them angry and increase the risk of suicide.
- **Fact** Asking someone directly about suicidal intent lowers anxiety, opens up communication and lowers the risk of an impulsive act.
- **Myth** Only experts can prevent suicide.
- **Fact** Suicide prevention is everybody's business, and anyone can help prevent the tragedy of suicide

QPR

Myths And Facts About Suicide

- **Myth** Suicidal people keep their plans to themselves.
- **Fact** Most suicidal people communicate their intent sometime during the week preceding their attempt.
- **Myth** Those who talk about suicide don't do it.
- **Fact** People who talk about suicide may try, or even complete, an act of self-destruction.
- **Myth** Once a person decides to complete suicide, there is nothing anyone can do to stop them.
- **Fact** Suicide is the most preventable kind of death, and almost any positive action may save a life.

How can I help? Ask the Question...

QPR

Suicide Clues And Warning Signs

The more clues and signs observed, the greater the risk. Take all signs <u>seriously.</u>

QPR

Direct Verbal Clues:

- "I've decided to kill myself."
- "I wish I were dead."
- "I'm going to commit suicide."
- "I'm going to end it all."
- "If (such and such) doesn't happen, I'll kill myself."

QPR

- "I'm tired of life, I just can't go on."
- "My family would be better off without me."
- "Who cares if I'm dead anyway."
- "I just want out."
- "I won't be around much longer."
- "Pretty soon you won't have to worry about me."

QPR

Behavioral Clues:

- Any previous suicide attempt
- Acquiring a gun or stockpiling pills
- Co-occurring depression, moodiness, hopelessness
- Putting personal affairs in order
- Giving away prized possessions
- Sudden interest or disinterest in religion
- Drug or alcohol abuse, or relapse after a period of recovery
- Unexplained anger, aggression and irritability

QPR

Situational Clues:

- Being fired or being expelled from school
- A recent unwanted move
- Loss of any major relationship
- Death of a spouse, child, or best friend, especially if by suicide
- Diagnosis of a serious or terminal illness
- Sudden unexpected loss of freedom/fear of punishment
- Anticipated loss of financial security
- Loss of a cherished therapist, counselor or teacher
- Fear of becoming a burden to others

QPR

Tips for Asking the Suicide Question

- If in doubt, don't wait, ask the question
- If the person is reluctant, be persistent
- Talk to the person alone in a private setting
- Allow the person to talk freely
- Give yourself plenty of time
- Have your resources handy; phone numbers, counselor's name and any other information that might help

Remember: How you ask the question is less important than that you ask it

QUESTION

Less Direct Approach:

- "Have you been unhappy lately?
  Have you been very unhappy lately?
  Have you been so very unhappy lately that you've been thinking about ending your life?"

- "Do you ever wish you could go to sleep and never wake up?"

QUESTION

Direct Approach:

- "You know, when people are as upset as you seem to be, they sometimes wish they were dead. I'm wondering if you're feeling that way, too?"
- "You look pretty miserable, I wonder if you're thinking about suicide?"
- "Are you thinking about killing yourself?"

NOTE: If you cannot ask the question, find someone who can.

PERSUADE

HOW TO PERSUADE SOMEONE TO STAY ALIVE

- Listen to the problem and give them your full attention
- Remember, suicide is not the problem, only the solution to a perceived insoluble problem
- Do not rush to judgment
- Offer hope in any form

PERSUADE

Then Ask:

- Will you go with me to get help?"
- "Will you let me help you get help?"
- "Will you promise me not to kill yourself until we've found some help?"

YOUR WILLINGNESS TO LISTEN AND TO HELP CAN REKINDLE HOPE, AND MAKE ALL THE DIFFERENCE.

REFER

- Suicidal people often believe they cannot be helped, so you may have to do more.
- The best referral involves taking the person directly to someone who can help.
- The next best referral is getting a commitment from them to accept help, then making the arrangements to get that help.
- The third best referral is to give referral information and try to get a good faith commitment not to complete or attempt suicide. Any willingness to accept help at some time, even if in the future, is a good outcome.

REMEMBER

Since almost all efforts to persuade someone to live instead of attempt suicide will be met with agreement and relief, don't hesitate to get involved or take the lead.

For Effective QPR

- Say: "I want you to live," or "I'm on your side...we'll get through this."
- Get Others Involved. Ask the person who else might help. Family? Friends? Brothers? Sisters? Pastors? Priest? Rabbi? Bishop? Physician?

For Effective QPR

- Join a Team. Offer to work with clergy, therapists, psychiatrists or whomever is going to provide the counseling or treatment.
- Follow up with a visit, a phone call or a card, and in whatever way feels comfortable to you, let the person know you care about what happens to them. Caring may save a life.

REMEMBER

WHEN YOU APPLY QPR, YOU PLANT THE SEEDS OF HOPE. HOPE HELPS PREVENT SUICIDE.

Suicide Prevention Resources

- **Insurance Plans**
- **EAP Programs**
- **1-800-423-TALK**
- **www.dhss.mo.gov**
- **www.dmh.mo.gov/cps/suicide/resources.htm**
- **Crisis Hotlines (DMH)**

Suicide Prevention Training

The Department of Mental Health recognizes the worthwhile benefit of proactive suicide prevention education. That's why we're offering a **FREE** suicide prevention training workshop (QPR), brought to your school, church, organization, place of business, etc. The workshop is approximately one hour and can be scheduled during lunch to accommodate employee work schedules.

Presented by a certified instructor, each QPR training includes information on:

- **the problem** of suicide nationally and in Missouri
- **common myths and facts** associated with suicide
- **the role of depression and chemical abuse** in suicide
- **warning signs** of suicide
- **basic intervention skills** to help avert suicide
- **ways of referring at risk** people to local resources

Attendees will receive the booklet "Ask a question, save a life" and card with information on suicide prevention, as well as resource information for treatment providers and support groups within their community.

To Schedule Suicide Prevention Training
Please call The Department of Mental Health
573-751-2794.

Rate, Number, and Ranking of Suicide for Each U.S.A. State*, 2002

Rank-State ('00 rank)	Rate	Number
01 Wyoming (04)	21.1	105
02 Alaska (06)	20.5	132
03 Montana (02)	20.2	184
04 Nevada (03)	19.5	423
05 New Mexico (01)	18.8	349
06 Arizona (10T)	16.2	886
07 Colorado (05)	16.1	727
08 West Virginia (07T)	15.3	276
09 Idaho (07T)	15.1	202
10 Vermont (26T)	14.9	92
11 Oregon (10T)	14.7	518
12 Utah (13T)	14.7	340
13 North Dakota (20T)	14.4	91
14 Oklahoma (09)	14.3	501
15 Florida (13T)	14.0	2,338
16 Arkansas (12)	13.9	377
17 Tennessee (20T)	13.4	778
18 Washington (24)	13.4	811
19 Kentucky (22)	13.2	540
20 Maine (19)	12.8	166
21 Kansas (36)	12.7	345
22 South Dakota (15)	12.4	94
23 Missouri (18)	12.2	693
24 Indiana (26T)	12.1	743
25 Mississippi (28T)	11.9	343
25 North Carolina (23)	11.9	986
27 Nebraska (35)	11.6	201
28 Alabama (28T)	11.5	514
28 Wisconsin (25)	11.5	627
30 Ohio (37)	11.3	1,287
31 Louisiana (34)	11.1	499
United States	**11.0**	**31,655**
32 Michigan (38)	11.0	1,106
32 Virginia (31T)	11.0	799
34 Pennsylvania (39T)	10.9	1,341
35 Iowa (39T)	10.7	314
35 South Carolina (28T)	10.7	440
37 Georgia (31T)	10.6	909
37 Texas (39T)	10.6	2,311
39 New Hampshire (17)	10.4	132
40 Minnesota (42)	9.9	497
41 Hawaii (31T)	9.6	120
42 California (46T)	9.2	3,228
42 Delaware (16)	9.2	74
44 Illinois (43)	9.1	1,145
45 Maryland (44)	8.7	477
46 Rhode Island (45)	8.0	86
47 Connecticut (46T)	7.5	260
48 Massachusetts (50)	6.8	436
49 New Jersey (49)	6.4	553
49 New York (51)	6.4	1,228
51 District of Columbia (48)	5.4	31

Caution: *Annual fluctuations in state levels combined with often relatively small populations can make these data highly variable. The use of several years' data is preferable to conclusions based on single years alone.*

Region [Abbreviation]	Rate	Number
Mountain [M]	16.9	3,216
East South Central [ESC]	12.6	2,175
South Atlantic [SA]	11.8	6,330
West North Central [WNC]	11.5	2,235
West South Central [WSC]	11.4	3,688
Nation	**11.0**	**31,655**
East North Central [ENC]	10.7	4,763
Pacific [P]	10.3	4,809
New England [NE]	8.3	1,172
Middle Atlantic [MA]	7.8	3,122

Source: Kochanek, K. D., Murphy, S. L., Anderson, R. N., & Scott, C. (2004). Deaths: Final data for 2002. National Vital Statistics Reports, 53 (5). Hyattsville, MD: National Center for Health Statistics. DHHS Publication No. (PHS) 2005-1120. (p. 92, Table 29) [data are by place of residence] [Suicide = ICD-10 Codes X60-X84, Y87.0]

Note: All rates are per 100,000 population.

* Including the District of Columbia.

Suicide State Data Page: 2002
26 September 2004

Prepared by John L. McIntosh, Ph.D. for

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"to understand and prevent suicide as a means of promoting human well-being"

Visit the AAS website at: www.suicidology.org

For other suicide data, and an archive of state data, visit the website below and click on the "Recent Suicide Statistics" link: http://mypage.iusb.edu/~jmcintos/

U.S.A. SUICIDE: 2002 OFFICIAL FINAL DATA

	Number	Per Day	Rate	% of Deaths	Group (Number of Sui.)	Rate
Nation	31,655	86.7	11.0	1.3	White Male (22,328)	19.9
Males	25,409	69.6	17.9	2.1	White Female (5,382)	4.8
Females	6,246	17.1	4.3	0.5	Nonwhite Male (2,344)	9.2
Whites	28,731	78.7	12.2	1.4	Nonwhite Female (568)	2.0
Nonwhites	2,924	8.0	5.5	0.9	Black Male (1,627)	9.1
Blacks	1,939	5.3	5.1	0.7	Black Female (330)	1.5
Elderly (65+ yrs.)	5,548	15.2	15.6	0.3	Hispanic (1850)	5.0
Young (15-24 yrs.)	4,010	11.0	9.9	12.1		

Completions: ***Suicide rate increased slightly in both 2002 and 2001 after declines for six consecutive years and a steady 2000 rate.***

- Average of 1 person every 16.6 minutes killed themselves.
- Average of 1 old person every 1 hour 34.7 minutes killed themselves.
- Average of 1 young person every 2 hours 11 minutes killed themselves. (If the 264 suicides below age 15 are included, 1 young person every 2 hours 3 minutes)
- 11th ranking cause of death in U.S. — 3rd for young

Cause	Number	Rate	Ages	Number	Rate
All Causes	33,046	81.4	10-14	260	1.2
1-Accidents	15,412	38.0	15-19	1513	7.4
2-Homicide	5,219	12.9	20-24	2497	12.2
3-Suicide	4,010	9.9			

- 4.1 male deaths by suicide for each female death by suicide.
- Suicide ranks 11th as a cause of death; homicide ranks 14th.

Attempts: (figures are estimates; no official U.S. national data are compiled)

- 790,000 annual attempts in U.S. (using 25:1 ratio)
- 25 attempts for every death by suicide for nation. 100-200:1 for young; 4:1 for elderly.
- 5 million living Americans (estimate) have attempted to kill themselves.
- 3 female attempts for each male attempt.

Survivors: (i.e., family members and friends of a loved one who died by suicide)

- *Each suicide intimately affects at least 6 other people.* (Estimate- Shneidman, 1969, *On the Nature of Suicide*)
- Based on the over 745,000 suicides from 1978 through 2002, estimated that the number of survivors of suicides in the U.S. is 4.47 million (1 of every 64 Americans in 2002); number grew by nearly 190,000 in 2002.
- If there is a suicide every 16.6 minutes, then there are 6 new survivors every 16.6 minutes as well.

Suicide Methods:

Suicide Methods		Number		Rate	Percent of Total
Firearm suicides		17,108	5.9	54.0%	
Suffocation/Hanging	6,462	2.2	20.4%		
Falls	740	0.3	2.3%		
Drowning	368	0.1	1.2%		
Poisoning	5,486	1.9	17.3%		
Cut/pierce	566	0.2	1.8%		
Fire/flame	150	0.1	0.5%		
All but Firearms	14,547	5.1	46.0%		

Old made up 12.3% of 2002 population but represented 17.5% of the suicides.
Young were 14.1% of 2002 population and comprised 12.7% of the suicides.

CPS Facts

SUICIDE

Suicide is a reaction to intense feelings of loneliness, worthlessness, hopelessness, or depression. Threats or attempts of suicide are calls for help. Knowing the warning signs and being prepared to answer these calls for help could prevent many suicides.

▼Why people commit suicide.

Problems that seem overwhelming may lead a person to think the only solution is to end his or her life. Suicide also can take place indirectly when a person's reaction to a problem leads him or her to act recklessly or ignore serious illness.

The following are some stressful situations that can trigger suicidal feelings:

- *Depression* – Depression is the leading cause of suicide. It can be caused by a personal loss, heredity, or a chemical imbalance in the body.
- *Crisis* – Major life changes, anger, humiliation, or frustration can lead a person to attempt suicide, sometimes before having had a chance to think it over.
- *Old age* – The changes wrought by old age can be frightening and may lead an older person to think of suicide an an alternative.
- *Substance abuse* – Substance abuse can weaken a person's self-control and lead to self-destructive behavior.

▼High risk groups.

While suicide knows no social or cultural boundaries, members of some groups are more prone to attempt or commit suicide than others. *You do not have to have a mental illness to have suicidal feelings.*

The following are considered high-risk groups:

- *The elderly* – Feelings of loneliness, loss of friends or spouse, loss of income and independence, and declining health often make older persons consider suicide as an alternative.
- *Young adults and college students* – Burdened with independence and responsibility for the first time, pressured to succeed in college or on the job, and faced with a world they seemingly cannot change, many young adults are overwhelmed and see suicide as an escape.
- *Business people and professionals* – The pressures to succeed and disillusionment over unfulfilled dreams place business people and professionals at risk.
- *Native Americans* – Life on the reservation, with its high rates of unemployment and substance abuse, and an exclusion from society's mainstream have led to suicide rates on some reservations five times that of the general population.
- *Minorities and the poor* – Despair brought on by discrimination, poverty, unemployment, and a feeling of being trapped, are causes of suicide.
- *Children* – Depression brought on by child abuse or neglect and an inability to communicate feelings or ask for help has led children as young as five years of age to commit suicide.

▼Suicide among young people.

Suicide is one of the leading causes of death among people ages 15 to 24. Young people are especially susceptible to suicide because they can experience many of the same stresses that face adults, in addition to the pressures of growing up. However, young people usually lack the network of support many adults have or a perspective on life and experience in dealing with problems that come with age.

▼Warning signs.

Suicide is rarely a spur-of-the-moment decision and most people give warning signs that they are contemplating taking their own lives. Some warning signs are:

- *Threats or previous attempts* – People who threaten suicide must be taken seriously, even if they have no intention of carrying out the threat. A previous attempt may have generated the attention a person was needing – and needing that attention again, the person may attempt suicide again.

- *Depression* – Anyone suffering from severe and prolonged depression is at risk of attempting suicide.
- *Personality or behavioral changes* – Someone who has been depressed or troubled and suddenly is better or seems to have resolved their conflicts may have decided upon suicide as a solution. Insomnia, loss of weight or appetite, loss of sexual drive, and withdrawal are also warning signs.
- *Preparations for death* – Someone suddenly making out a will, putting their affairs in order, giving away personal possessions, or acquiring the means of committing suicide (buying a gun, stockpiling sleeping pills, etc.), is sending out a warning sign.

▼How you can help.

One of the misconceptions of suicide is that someone who has decided to take his or her life is beyond help. In most cases, the crisis period when a person is actually considering taking his or her life is limited. The person can be helped past this period.

Another misconception is that mentioning suicide may give the person the idea. If somone is showing warning signs of being suicidal, that person has already thought about it. Talking frankly about it can actually help prevent a person from acting on the idea.

Here are ways to help:

- *Give emotional support* — Don't challenge the person, but take him or her seriously and offer to help. Listen to what the person has to say. Try to explain that, with help, the problem can be overcome and that things can get better. *Stay with the person until help is available or until the crisis passes.*
- *Encourage positive action* Suggest steps the person can take to improve the situation. Help the person to stay busy, balancing both work and recreation. The recreation should include physical exercise that will help the person relax and sleep better. Suggest a change of pace or scenery to gain a new perspective.
- *Seek professional help*— This can be obtained from suicide prevention centers, physicians and mental health professionals, members of the clergy, community mental health centers, or school counselors.

▼What else to do?

People who attempt suicide also face the stigma attached to it by society. This stigma causes discrimination in employment, housing, health care, and in the ability to buy health insurance. By learning more about mental illness and the effectiveness of treatment, this discrimination can end, removing the stigma that acts as a barrier to successful treatment.

For more information, contact the nearest community mental health center or the Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services
P.O. Box 687
1706 East Elm
Jefferson City, MO 65101
573-751-5212
modmh.state.mo.us

Sponsored by Missouri Advisory Council for Comprehensive Psychiatric Services.

CPS Facts

GRIEF

Loss can happen at any time, but it usually catches us unprepared. Loss comes in many forms—losing a relationship, a job, a beloved pet, or some aspect of your health—all capable of evoking profound pain and grief.

Grief is a natural response to life-changing loss. While each person grieves differently and deals with different losses in different ways, the grieving process itself is the same, as well as its ultimate goal, acceptance of new circumstances.

Therapists and counselors who work with grieving clients recognize different facets of the process, which may or may not occur sequentially. Shock and denial are often the first reaction to loss. Denial is a natural anesthetic and may be quite useful as a mechanism to permit a basic level of functioning at a time when the full impact of grief could be devastating. Denial may be succeeded by, or alternate with, a range of powerful emotions, including guilt, anger (at the loss itself, the person who is gone, or God), and extreme sadness. For many people this depth of sadness is a necessary part of the grieving process, because it represents unconscious acceptance of the loss. When acceptance becomes conscious, the loss can be assimilated—in some cases even perceived as a gift that opens a new phase of life.

Despite the difficult nature of the grieving process, it's important not to avoid or ignore it. If you do, suppressed grief may resurface and affect your physical and mental well-being when you're facing another loss.

Deborah Morris Coryell, co-founder and president of the Shiva Foundation, a nonprofit organization in Santa Fe, New Mexico, that's dedicated to promoting the understanding of grief, explains, "You must step up to your grief, meet it, and embrace it. Once you do that, grief begins to teach you—for example to recognize your hidden strengths, to be more compassionate, and to realize the preciousness of what you have. Everyone of us is changed by our losses. The challenge is to use the loss as a pathway into some greater wholeness."

Coping with loss

- *Initially, take a break from your routine responsibilities.* Ask family and friends for specific kinds of help, such as meal preparation or child care.

- *Talk about your feelings* with family, friends, clergy, or spiritual advisors. Many people find it therapeutic to share their memories of the person who died or to speak at a memorial service or funeral.

- *Use creative outlets such as writing, art, or music* to express your feelings and work through grief. You may find it helpful to write a journal, poetry, a book of memories, or even a letter to the person who died.

- *Allow yourself to cry.* Crying is a natural response to pain and the emotional release it provides can be both cleansing and healing.

- *Take care of yourself.* Grief can depress the immune system. So make every effort to eat well and remain physically active to counteract the stress. Grieving can be physically and emotionally exhausting. Make time for extra rest and sleep.

• *Practice breathwork to relieve stress.* Simply observing your breath can help you to stay "centered" in your body when your mind feels agitated. Deep breathing provides natural calming.

• *Be patient with yourself.* You may feel pressure to "get on with your life," but research suggests that intense grieving typically lasts from three months to a year after the death of a loved one. Acknowledging the long-term nature of grieving (and the ups and downs of the process) can help ease your mind. In addition, try to avoid making major decisions (moving, changing a job, etc.) for at least a year after the significant loss.

• *Consider joining a bereavement group.* Such groups offer comfort, compassion, and companionship.

• *Consider seeing a grief counselor.* If you need additional support or feel "stuck" in your grieving process, speak with a counselor who is well-trained to help with this difficult time.

• *Watch for signs of being overwhelmed by grief,* such as recurrent thoughts of suicide or severe difficulty with basic functioning for months after the initial event. If you notice these signs, seek help from a mental-health professional.

• *Make time for diversion and fun.* Give yourself permission to take a break from grieving and to enjoy yourself. Laughter can be a great stress-reducer.

• *Transform your grief into action.* In time, grief prompts some people to rethink their priorities. Volunteer for a cause close to the deceased, establish a memorial scholarship, or take some other positive action. Says Coryell: "To continue to be in the presence of someone you love after death, you need only act positively on their behalf. And, not only are you again with them, but they live on for others as well."

▼ When others grieve

When someone you know loses a loved one, it's natural to want to offer sympathy and support. Yet, many people feel unsure of how to do so. Here are some practical ways to help a person who is grieving:

- ▼ Offer to visit. Your presence can be a tremendous comfort
- ▼ Acknowledge the loss, pain, and hurt. Let them know that you've been thinking about them.
- ▼ Listen without giving advice or telling the person what they should feel. Don't claim to know how they are feeling. Be accepting of tears.
- ▼ Share your memories and don't be afraid to use the name of the person who died.
- ▼ Share a hug, a handclasp, or a shoulder to cry on.
- ▼ Offer specific help—such as preparing a meal, helping with household chores, or running errands—rather than making a vague offer to "Call me when you need help."
- ▼ Avoid cliches and religious platitudes such as "It all happened for the best" or "It was God's will."
- ▼ Don't suggest the deceased can be replaced by a new spouse, another child, or a pet.
- ▼ As time passes, don't try to rush the bereaved by saying "You should be over it by now" or "It's time to put this behind you."
- ▼ Stay in touch, particularly during difficult times such as anniversaries, birthdays, holidays, or the day of the death.

For more information, contact the nearest community mental health center or the Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services
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1706 East Elm
Jefferson City, MO 65101
573-751-5212
modmh.state.mo.us

CPS Facts

DEPRESSION

Everyone suffers from depression from time to time. It's a natural defense mechanism that allows the mind to take a rest by causing an individual to withdraw from reality for a day or two. But for some people, the withdrawal is deeper and lasts longer. It interferes with their lives and can lead them to substance abuse or suicide as a means of escape. When this happens, a person is said to have a mental illness called severe depression.

▼ Types of depression.

There are three types of depression:

- Mild depression is the most common and can be brought on by both happy and sad events. A wedding is certainly happy, but also very stressful, and the stress can be depressing. Another common cause is childbirth, which may lead to post-partum blues. While usually mild, it can become severe.
- Moderate depression, or a feeling of hopelessness, lasts longer and is more intense. Moderate depression is often brought on by a sad event, such as a death of a loved one or loss of a job. It usually does not interfere with daily living, but can become severe. If it persists, professional help may be warranted.
- Severe depression can cause a person to lose interest in the outside world, can cause physical changes, and can lead to suicide. A person with severe depression requires professional treatment.

Note: Bipolar disorder is a mental illness characterized by extreme mood swings from mania (excessive excitement or joy) to deep depression with many of the same symptoms and causes as depression, but requiring a different course of treatment. This illness is also known as bi-polar disorder.

▼ Who is affected.

One in five people suffers from depression at some point in their life. Depression can strike anyone, even children and babies who have been abused or neglected.

Middle-aged adults, however, are more likely to become depressed than any other age group.

While depression is often associated with loneliness, married people are more likely to become depressed than single people. Women are twice as likely as men to become depressed.

▼ Symptoms.

The symptoms of depression range from feeling "down" to feeling suicidal. A slowing down or neglect in performing daily tasks, irritability, poor memory, or changes in behavior are all symptoms. A loss of sexual desire or loss of warm feelings toward family members, a lack of pleasure in anything, or a loss of self-esteem can be symptoms. Physical changes can include sleep disturbances, fatigue, unexplained headaches or backaches, digestive problems, and nausea.

All of us at some time experience one or more of these symptoms. But when they become persistent and so severe that pain and other problems outweigh pleasure much of the time, then it is time to seek professional help.

▼ Causes.

There is no one cause for depression. Personality, personal relationships, physical health, and genetics are all factors. People who are highly self-critical, very demanding, or unusually passive may be prone to depression. Problems with a spouse, a child, or an employer can cause depression. Imbalances in the chemicals in the brain due to illness, infection, or medications can be a cause. Substance abuse can be a symptom of depression, but also a cause. And while depression cannot be inherited, it does seem to be more prevalent in some families.

▼ Treatment.

As with most illnesses, treatment is easiest and most effective when begun early. A combination of the following is often used:

- *Medication* is often used in cases of severe depression and can bring relief in three to four weeks.
- *Psychotherapy* in the forms of counseling, group sessions, and psychoanalysis are valuable tools in treating depression.
- *Electroconvulsive therapy*, or "shock therapy," involves administering mild electrical shocks to the brain while a patient is under anesthesia.

▼ Prevention.

Depression cannot always be avoided, but because it is often related to stress and physical problems, it is possible to lessen the chances of becoming severely depressed. Here are some tips:

- Take time for a favorite activity as a way to relax and relieve stress.
- Get plenty of exercise to maintain a healthy body, to relieve tension, and to help get a good night's sleep.
- Don't try to be Superman or Superwoman. Know your limitations and avoid stressful situations.
- Cultivate friendships to have someone to talk to who can provide support.
- Don't be afraid of feelings. There's nothing wrong with being mildly depressed. But if you feel it is more than mild depression, don't hesitate to see a physician.

▼ What else to do?

People with depression or any mental illness also face the stigma attached by society to these illnesses. This stigma causes discrimination against people with a mental illness in employment, housing, health care, and the ability to buy health insurance. By learning more about mental illness and the effectiveness of treatment, this discrimination can end, removing the stigma that acts as a barrier to successful treatment.

▼ Suicide.

Severe depression sometimes leads to a suicide attempt. Suicide threats or attempts must be taken seriously even if there is no intent to actually die. Warning signs include making out a will, giving away personal possessions, saying goodbye or suicide preparations, such as buying a gun or stockpiling pills. If you become concerned that a depressed person may be thinking of suicide, ASK THEM IMMEDIATELY.

Here are ways to help:

- Give emotional support — Don't challenge the person, by take him or her seriously and offer to help. Listen to what the person has to say. Try to explain that, with help, the problem can be overcome and that things can get better. Stay with the person until help is available or until the crisis passes.
- Encourage positive action — Suggest steps the person can take to improve the situation. Help the person to stay busy, balancing both work and recreation. The recreation should include physical exercise that will help the person relax and sleep better. Suggest a change or pace or scenery to gain a new perspective.
- Seek professional help — This can be obtained from suicide prevention centers, physicians and mental health professionals, members of the clergy, community mental health centers, or school counselors.

For more information, contact the nearest community mental health center or the Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services
P.O. Box 687
1706 East Elm
Jefferson City, MO 65101
573-751-5212
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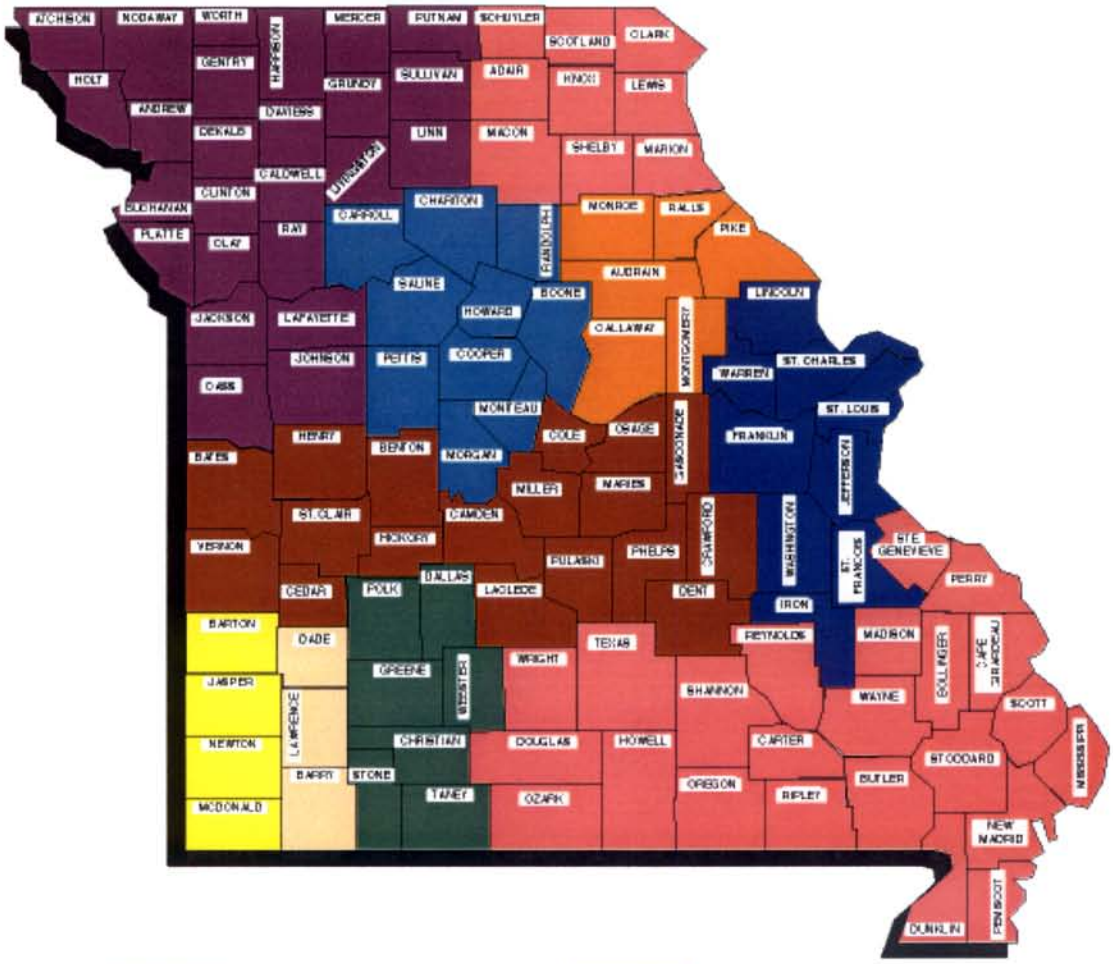
Statewide 24-Hour Crisis Hotlines



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